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Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: State of Indiana

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

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, Governor, State of Indiana (Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Position/Title: Director, Children's Health Insurance Program
Name: Melanie Bella	Position/Title: Assistant Secretary, Office of Medicaid Policy and Planning
Name:	Position/Title: Secretary, Indiana Family and Social Services Administration

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. X A combination of both of the above. (Medicaid expansion under Phase I of the CHIP program was approved June 26, 1998. State-designed child health program under Phase II of the program was approved December 22, 1999.)

1.2 X Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 X Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: Phase I of Indiana's program was effective on June 26, 1998 and Phase II of Indiana's program was effective on December 22, 1999.

Implementation date: Phase I of Indiana's program was implemented on July 1, 1998 and Phase II of Indiana's program was implemented on January 1, 2000.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Low-Income Children:
The total number of Indiana children under 19 is estimated to be 1,569,000 according to Census Bureau CPS data. The estimate is a three-year average of the 1998, 1999 and 2000 CPS data.

Eighty-five percent of the children in Indiana are estimated to be Caucasian; 10% are estimated to be African-American; 3.5% are estimated to be Hispanic; 1% are estimated to be Asian; and less than 1% are estimated to be Native American.

Using the reported average of the 1998, 1999 and 2000 CPS data, it is estimated that there are 520,000 children in the State who are under 200% of the Federal Poverty Level (FPL).

Health Coverage of Low-Income Children:
The March 1999 Employee Benefit Research Institute (EBRI) analysis of the March 1998 CPS data found that the uninsured rate for children in Indiana was 12.4%. According to a telephone survey commissioned by the State of Indiana in the spring of 2000, 13.1% of children with family incomes less than 150% FPL were uninsured, and 8.7% of children with family incomes between 150-200% FPL were uninsured. It is estimated that about half of all uninsured children under 200% FPL reside in the six largest counties of the State. Certain other counties also have a high number of uninsured children.

ver 430,000 children in Indiana enrolled in the Hoosier Healthwise program (the State's managed care program for Medicaid and CHIP). Approximately, 65% of these children are White, 25% Black, 8% Hispanic and less than 1% Native American Asian. Half of these children reside in the six largest counties in the State. The Medicaid expansion under Phase I of CHIP and the heightened outreach program has resulted in a significant increase in the number of children enrolled in Medicaid. Since July 1, 1998, there has been a net increase of 220,000 children enrolled in Hoosier Healthwise.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Medicaid:

The primary public health insurance available in Indiana is through the Medicaid program. In recent years, Hoosier Healthwise, Indiana's managed care program under Medicaid, has been phased-in. As was previously mentioned, over 430,000 children are currently enrolled in Hoosier Healthwise under either Title XIX or Title XXI. Hoosier Healthwise is comprised of a Primary Care Case Management (PCCM) system and a Risk-Based Managed Care (RBMC) system. Under both of these systems, primary medical providers (PMPs) provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services. Children who became eligible under the CHIP program have been integrated into these managed care networks.

Families of eligible children are given thirty days from the date of enrollment to choose a PMP. In cases where a family fails to choose a PMP within the thirty day time period, an assignment is made by the program. Enrollment in the PCCM system and the RBMC system is determined based upon which program the PMP participates. Where the PMP participates under the RBMC system, the child is enrolled in the RBMC system, and where the PMP participates under the PCCM system, the child is enrolled in the PCCM system. Families who wish their child to be enrolled in one of the specific systems choose a PMP who participates under that system.

Individuals currently apply for Hoosier Healthwise at one of more than 500 enrollment centers or 120 Division of Family and Children (DFC) offices located throughout the State. Over 1,500 Public Assistance caseworkers have responsibility for processing Hoosier Healthwise applications. Individuals can apply at any of the various enrollment centers or file an application by mail. If a DFC caseworker is not on site, the application is forwarded to the local DFC office for authorization. In order to facilitate enrollment of eligible newborns, many local offices also have arrangements with the hospitals in their communities, whereby the hospitals inform the caseworkers of babies born to Hoosier Healthwise recipients. These children are enrolled in the program without the parent having to contact the DFC office.

Other Child-Related Programs:

There are a number of other public programs in Indiana that provide health related

services to children. DFC caseworkers refer families for these services, where appropriate. As these child-related programs engage in outreach activities that target individuals eligible for the services they offer, they also strive to identify other programs for which the children may be eligible and to make the appropriate referrals.

The Healthy Families Indiana Program, a voluntary home visitation program, is designed to prevent child abuse and neglect by linking families to a variety of services, including child development, health care, and parent education programs. The Healthy Families Indiana Program strives to ensure that every child has a medical home and that every child has up to date immunizations. Healthy Families also makes referrals to Hoosier Healthwise and various other child-related programs in the State. Each individual community develops its own Healthy Families outreach plan.

The Children's Special Health Care Services (CSHCS) program is an insurance program that provides medical assistance to approximately 8,000 families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs throughout the State. CSHCS requires that children who apply for the program also apply for Medicaid. Children with special medical needs and their siblings who are eligible for Medicaid are identified by the CSHCS care coordinator when the care coordinator first receives the case and also during the annual re-evaluation. Applications for the CSHCS program are taken by the newborn intensive care unit at Riley Hospital for Children, the only children's hospital in the State. To help identify eligible children and to streamline administrative hurdles, the CSHCS program has developed a combined intake system with other public programs. Each county has a single point of entry which can take a combined Hoosier Healthwise, CSHCS, First Steps, and SSI application. This collaboration has resulted in a large increase in the number of children served by the CSHCS program.

The Indiana Maternal and Child Health (MCH) program requires direct service grantees to facilitate their clients into Medicaid if they meet eligibility requirements. Children under 100% of poverty are served free of charge. MCH funds 22 child or adolescent health clinics and 4 school based health clinics. Services for children are also provided at other MCH sites. Forty-two of the 50 MCH grantees are Medicaid providers, and several of these act as PMPs under Hoosier Healthwise. Each individual MCH grantee handles its own outreach and marketing. Grant applications address collaborative efforts. The MCH grantees also document referrals to other programs on the encounter forms and enter that information into the project data base, so that follow-up can be performed during the next visit.

The MCH program also operates the Indiana Family Helpline which provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals.

MCH clinics also participate as Hoosier Healthwise enrollment centers. The Helpline is advertised through flyers distributed throughout the State. The telephone number is also included in mailings which are sent to consumers by the Family and Social Services Administration (FSSA).

Local Health Departments (LHDs) provide immunizations, lead screenings and other direct services to individuals throughout Indiana. Many of these activities are funded with federal and state dollars channeled through the Indiana State Department of Health (ISDH). Some LHDs have special staff dedicated specifically to outreach activities. The state is currently working to increase coordination between the ISDH lead screening and immunization programs and the Hoosier Healthwise program. Efforts are also being made to coordinate provider participation in the various programs.

Indiana has a Step Ahead initiative which is designed to develop, at the local level, comprehensive seamless delivery systems for children from birth to age thirteen. The initiative is designed to support county efforts to centralize programs in order to reduce duplication and fragmentation of services. Local Planning Councils work to address child issues in the community. At the state level, Step Ahead strives to coordinate funding streams and remove barriers that create problems for families and providers.

First Steps, Indiana's early intervention system for infants and toddlers who have developmental delays, brings together federal, state, local, and private funding sources in order to create a coordinated, community-based system of services. In each community, a "child find" system is developed and is utilized to identify, locate and evaluate children who are eligible for early intervention services. Networks of traditional and non-traditional providers are established. Providers in the networks include MCH programs; community mental health centers; Women, Infants and Children (WIC) programs; developmental disabilities agencies; MCH agencies; CSHCS programs; private health care providers; child care providers; United Way agencies; and independent providers and service coordinators. First Steps collaborates with the DFC by distributing information about the Hoosier Healthwise program.

Very important health care services for children are also provided by Community Health Centers (CHCs). These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities and some serve as Hoosier Healthwise enrollment centers.

Special Populations:

The State has several initiatives designed to assure that health services are provided to special populations. The ISDH has developed a collaboration with the Indiana Minority Health Coalition (IMHC) to promote healthy lifestyles through disease prevention and health awareness; and, to provide referrals, information services, community outreach, and program services. The ISDH provides the state and local Coalitions with funds for

health promotion activities. The agency also collaborates with these coalitions on outreach activities for the immunization program and other programs administered by the agency. In addition, Indiana has developed statewide enrollment partnerships with Indiana Black Expo, the Wishard Hospital Hispanic Health Project and the Indiana Primary Health Care Association (IPHCA).

A Consolidated Outreach Project (COP) provides intake assessment for migrant farmworkers who enter Indiana for seasonal employment. The project is offered through a FQHC and is funded by the DOE, Department of Workforce Development, the Social Services Block Grant, and the Community Services Block Grant. Through the COP project, families are referred to the various health care programs and other programs for services while they are in the state.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Since the implementation of CHIP in Indiana, the State has instigated various initiatives that provide health services to children through collaborative public and private efforts. These efforts include a collaboration between the ISDH and the IPHCA; managed care contracts between the Division of Mental Health (DMH) and managed care providers; and a health insurance high risk pool for medically challenged individuals that is financed through a partnership between the beneficiaries, the health insurance industry and the State. In addition, the Medicaid program and the CSHCS program may both be considered public/private initiatives due to the fact that these programs contract with private providers to provide services to beneficiaries.

Through a collaborative arrangement between the ISDH and the IPHCA, health care services are provided to children and other individuals throughout the State. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farmworkers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers. The IPHCA also received a grant to promote the development of enrollment centers in federally qualified health centers (FQHCs). This grant was used to augment the state outreach efforts.

The ISDH also worked collaboratively with IPHCA to allocate funds that the General Assembly earmarked for CHCs. Start-up and planning funds were provided in the 1995 biennium budget, and funds for expanding existing services, start-up and planning were provided in the 1997 and 1999 biennium budgets. Applicants for these funds were required to address community needs, special populations, and collaborative linkages. Many of the CHCs utilize outreach workers to market their services to potential clients in

the individual communities. These outreach workers often go door to door to target potential clients. CHCs located in areas with high concentrations of Hispanics and migrant farm workers use Spanish speaking outreach workers and providers. As part of the COP partnership, the CHCs provide health services to migrant farmworkers.

The DMH has undertaken a collaborative effort with mental health providers throughout the state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and, in return, provide a full array of mental health services to seriously emotionally disturbed children who are at 200% of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the DOE Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of this pilot project is to provide community-based services to children and youth in Marion County who are seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to the program come primarily from the Office of Family and Children, the DOE and the Juvenile Court.

A partnership between the health insurance industry and the State is the underlying principle behind the financing of an insurance risk pool for medically challenged individuals who are unable to obtain traditional health insurance. The Indiana Comprehensive Health Insurance Association (ICHIA), a private non-profit association created by the Indiana General Assembly, covers adults and children. State programs make referrals to ICHIA where appropriate. ICHIA is funded through premiums, and an assessment on insurance companies licensed in the State. Since the insurance companies are able to obtain a State tax credit for these assessments, the State is an important partner in this initiative as well.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The CHIP Phase II program, the CHIP Phase I Medicaid expansion, and the Title XIX Medicaid program are all closely coordinated. Individuals who apply for benefits will be considered for each of the programs. Since the CHIP program is a component of Hoosier Healthwise, the CHIP program utilizes the same delivery system as is already in place for Medicaid. The goal is to provide a medical home for each child, and to establish a seamless system of care.

Hoosier Healthwise is also coordinated with the CSHCS and First Steps programs so that children with special needs are able to receive the various services they require. The programs established a common application form, provide referrals to the other programs, and a committee on children's special health care needs meets quarterly to continue to improve upon current coordination efforts.

Indiana has taken significant steps to coordinate CHIP outreach and enrollment with that of other public and private programs throughout the State. These endeavors have utilized a myriad of public and private entities to maximize the number of individuals reached, and to make the enrollment process convenient for families.

Indiana's Title XXI Medicaid expansion, or Phase I of the State's CHIP plan, limited family income to 150% of poverty. This serves as an indirect measure to address crowd-out as many of the lower income families do not have the option of employer-based health insurance. Since a higher income threshold is used under the CHIP Phase II program, crowd out is of greater concern. Therefore, Indiana invested considerable time examining various crowd out deterrents that could be utilized under Phase II. A Subcommittee of various experts was formed to address eligibility and crowd out issues. Michael Birnbaum, an expert on crowd out issues from the Alpha Center was also consulted. After a rather extensive analysis, the State decided to utilize, for the Phase II program, two primary mechanisms for addressing crowd out: premiums and waiting periods.

Under Phase II, sliding scale premiums for those above 150% of FPL are imposed. This ensures that children of families with lower incomes will be favored over children of families with higher incomes. With certain exceptions for those who lose coverage involuntarily, a three-month waiting period is required before individuals who previously had creditable health coverage are able to enroll in the program. These two mechanisms provide appropriate disincentives for substituting CHIP coverage for employer-based coverage.

By integrating CHIP and Medicaid outreach efforts, developing a joint application form, utilizing a Medicaid expansion approach for Phase I of the CHIP program, and integrating the administration and delivery systems of the Phase II CHIP program into the Hoosier Healthwise program, the State will assure that the CHIP and Medicaid programs are closely coordinated. This ensures that the programs are coordinated not only for the benefit it provides to enrollees, but also for the purpose of administrative simplification and efficiency. For example, FSSA has modified ICES, IndianaAIM, FSSA's cost allocation plan, and other related systems to correctly reflect expenditures eligible for reimbursement from Indiana's federal CHIP allocation.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Rather than duplicate the delivery system already in place for Indiana's Medicaid program, Indiana's CHIP program will utilize the Hoosier Healthwise delivery system. Access to specialty care will be the same for CHIP as it is under Medicaid Hoosier Healthwise; the same services will be carved out of both Medicaid and CHIP; the same vendors will be used (except a premium vendor will also be utilized under CHIP Phase II); and all participating Medicaid providers, including clinics, will be considered providers under CHIP. The Phase II CHIP program differs from the Medicaid component of Hoosier Healthwise primarily in the areas of eligibility, benefits and cost-sharing.

Hoosier Healthwise is divided into two systems: a PCCM system and a RBMC system. Both the PCCM system and the RBMC system are managed care programs that utilize PMPs to provide primary care services, make appropriate referrals for specialty services, and monitor health care utilization. Both of these programs, which operate under a 1915(b) waiver, require that health services be provided by either the PMP or another provider to whom the recipient was referred by the PMP. Hoosier Healthwise currently has an extensive provider network in place, and the program continuously reviews provider network availability, member enrollment and expected member enrollment, to determine where provider participation needs to be increased. Still, there are several counties where the State wants to increase the number of PMPs serving the county.

Families of children enrolled in Hoosier Healthwise have 30 days to select a PMP from a list provided to them. Assistance in selecting a PMP and choosing between the various managed care options is provided by Benefit Advocates (BAs) in each county. If a family fails to make a selection, an auto-assignment is made which takes into consideration the family's geographic region, and, in cases of re-enrollment, the last provider of care. The auto-assignment rotates placements between the PCCM system and the RBMC system. With certain restrictions, opportunities are available for changing PMPs.

Providers who serve as PMPs may choose to participate in both the PCCM and the RBMC systems; however, they may accept new recipients in only one of the two systems. In the case of the RBMC system, PMPs may only participate in one managed care organization (MCO) in each region. With limited exceptions for former patients, new family members, and medically underserved areas, the PMP panel size is limited to a maximum of 2,000 combined Medicaid and

CHIP recipients for both the RBMC system and the PCCM system together. PMPs are expected to accept a minimum of 150 enrollees, and must be available to see patients at least 20 hours per week, with certain exceptions. In addition, PMPs, or their clinically qualified designees, must be available 24 hours a day, 7 days a week. The 24-hour number is monitored randomly to assure compliance with this requirement.

are currently1636 pediatric and family practice PMPs enrolled throughout the state To serve as a PMP, a physician must be in one of the following specialty areas: family practice, pediatrics, general practice, obstetrics/gynecology or internal medicine. PMPs can practice in any setting, including in FQHCs.

PMPs are available to enrollees in every county in the State. Between September of 1999 and July of 2002, almost 150 pediatric and family practice PMPS have joined the Hoosier Healthwise program. Targeted recruitment efforts are currently being focused on several counties where the State wants to increase the numbers of PMPs serving the county. For these counties, new enrollees may either remain in the fee for service program whereby they can access any Medicaid enrolled physician, or choose PMPs in contiguous counties.

he PMP to recipient ratio approximately 234 enrollees for every pediatric or family practice PMP. Public Law 273-1999 mandates that providers who participate under the Medicaid program are also considered to participate under the CHIP program. Even if all of the estimated eligible children were to enroll in CHIP and Medicaid, the average enrollment perPMP would still be significantly below the maximum PMP panel size.

PCCM System:

The PCCM system, called PrimeStep, is composed of PMPs who practice in the various counties throughout the state. PMPs who participate under PrimeStep must comply with the PMP standards addressed above.

Providers who choose to participate in the PCCM program enroll directly through the State. These providers receive a patient management fee of $3 per month for each enrollee. Reimbursement for health care services is paid on a fee for service basis.

RBMC System:

Under the RBMC system, the OMPP contracts, through a competitive bidding process, with MCOs to provide health care services for Medicaid recipients enrolled in their managed care plan. Providers who serve as PMPs under the RBMC program enroll directly with the individual MCOs. Each MCO is paid a fully capitated rate per enrollee. The OMPP and the DOI regulate MCOs' fiscal solvency by establishing minimum net worth and reserve amounts. The OMPP is also responsible for monitoring the contractors and providing quality assurance.

Indiana is currently contracting with three MCOs: Harmony Health Plan in the northern region of the state, MDWise in the central region, and Managed Health Services statewide.

MCOs who participate under the RBMC system must have a provider network that is capable of offering quality care and meeting the needs of recipients within the region. MCOs must ensure that they have a comprehensive network development plan in place and that the participating PMPs have 24-hour coverage available 7 days a week. The MCOs must target areas where further network development is needed, prioritize target areas and establish workcharts with project completion timelines. The development plans must be updated quarterly. Special priority must be given to network development in rural areas.

MCOs must also have a process in place for handling the differing needs of enrollees based on culture, race, disability and language. In addition, MCOs are required to have credentialing policies in place, and procedures for monitoring and sanctioning providers. Where MCOs fail to comply with contract requirements, the State can impose liquidated damages, suspend monthly premium payments and/or suspend the right to enroll new participants.

Indiana Public Law 291-2001 states that Medicaid recipients eligible for enrollment in a Medicaid managed care program, and who reside in a county having a population of between 150,000 and 700,000 must enroll in a risk-based managed care program. Currently, seven Indiana counties meet this criteria and have transitioned or will transition to a mandatory managed care system. CHIP recipients are also a part of this transition, because all Medicaid providers must also be CHIP providers under Indiana state law.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Hoosier Healthwise has a number of utilization control mechanisms in place that are designed to ensure that health care use is appropriate and medically necessary.

Indiana utilizes the Medicaid Management Information System (MMIS), developed by the United States Department of Health and Human Services, to control program costs and increase efficiency within the Hoosier Healthwise program. The MMIS contains a Surveillance and Utilization Review (SUR) Retrospective Analysis Management System (RAMS II) subsystem, which together with the IndianaAIM system (Indiana's MMIS), provides a comprehensive method for conducting utilization review and program management. Under this system, computerized reports are generated that provide a statistical profile of provider practices and recipient utilization. The system allows for the flagging of areas where there is deviation from peers. Rankings are made to indicate which individuals have the greatest amount of deviation. SUR analysts work with the Associate Medical Director, and further action is taken where

warranted. The objective is for misuse of health services to be identified, investigated, and corrected. Provider desk reviews are conducted based upon Federal and State requirements, and prepayment review and other action is taken where warranted. Recipient restricted card procedures are implemented in cases of recipient overutilization.

Specific mechanisms designed to prevent overutilization are also built into the Phase II CHIP program. Limitations are placed on the benefit package and nominal copayments will be imposed for certain services. A more detailed discussion regarding benefits can be found in Section 6; and a more detailed discussion regarding copayments can be found in Section 8.

The managed care system established under Hoosier Healthwise also has some built in utilization controls. The PMP serves as a gatekeeper who provides or authorizes primary care services and makes referrals for specialty care (except those which may be self-referred) where appropriate. Referrals must be documented in the patient's medical record.

In addition, MCOs are required to have written utilization review (UR) programs in place. The program must include a utilization review committee directed by the Medical Director of the MCO; utilization management practices that conform to industry standards; and resources for evaluating, and, if necessary, modifying the UR process.

In order for the State to track expenditures and service utilization in the RBMC program, shadow claims are required to be reported for patient encounters. The shadow claims provide details regarding diagnoses, procedures, place of services, billed amounts and providers.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. Geographic area served by the Plan: N/A

4.1.2. X Age: Children must be less than 19 years of age

4.1.3. X Income: Family income must be more than 150% of FPL to no more than 200% FPL. Families with higher incomes will be subject to higher premiums. (A more detailed discussion on cost sharing can be found in Section 8).

4.1.4. Resources (including any standards relating to spend downs and disposition of resources): N/A

4.1.5. X Residency (so long as residency requirement is not based on length of time in state): Children must be residents of Indiana.

4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): N/A

4.1.7. X Access to or coverage under other health coverage: Children cannot have other creditable health care coverage. A three-month waiting period from the date the child was last covered will be imposed. Exceptions to the waiting period will be provided if the coverage was lost involuntarily (such as through the loss of employment, divorce etc) or if the child was previously covered by Medicaid.

4.1.8. X Duration of eligibility: Children remain eligible as long as they meet income and other program requirements. Eligibility is redetermined at twelve months if CHIP is the only State program the child is enrolled in. Children whose families are also enrolled in Hoosier Healthwise plus other State programs, including TANF or food stamps, will be redetermined every three to six months. Families are asked to notify their

caseworker if their income increases or if health insurance coverage is obtained during the eligibility period. Also, if during the third party liability (TPL) matching process, it is discovered that a child obtains other health coverage, an alert will be sent to the caseworker so that eligibility can be redetermined. (A more detailed discussion of TPL can be found in Section 4.4.1)

4.1.9. X Other standards (identify and describe):

- To be eligible for Phase II of CHIP, families must agree to cost-sharing requirements.
- The CHIP program is also permitted to adjust eligibility requirements based upon available resources.
- Applicants must provide a Social Security Number in order to be eligible for the program, as permitted in 42 CFR 457.320.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. X These standards do not discriminate on the basis of diagnosis.

4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The application process and eligibility determination process for Phase I and II of the CHIP program is integrated into the application and eligibility determination process for Hoosier Healthwise. The two-page Hoosier Healthwise enrollment form and the accompanying enrollment book includes the Phase I and II CHIP programs. Families who apply for benefits will be advised of the cost sharing requirements under CHIP II (or Package C), and, to be considered for eligibility under CHIP II, they must sign a statement indicating that they agree to meet the cost-sharing requirements if the child is found eligible.

Eligibility determinations for CHIP are made by the DFC. The DFC also has responsibility for eligibility determinations under Title XIX. Since the same application form, income definition, and income methodologies are utilized, administrative efficiencies are enhanced. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. A more detailed discussion of the screening process can be found in

Section 2.3.

Before an application will be approved, income of a parent or guardian must be verified by supporting documentation from the payer. Acceptable items for verifying earnings include: pay stubs, statements from employers, or a wage verification form that is completed by employers.

When it is determined that a child is eligible for the Phase II program, a conditional approval notice will be sent to the family and a record will be sent to the premium collection vendor. Once the first premium payment is made, the child becomes enrolled in the program. A detailed discussion of cost-sharing responsibilities and the premium payment process can be found in Section 8.

As required by the Balanced Budget Act (BBA), Indiana will conduct follow-up screening to identify when coverage is available through another plan. Families will be required to notify the State if other health coverage is obtained. CHIP coverage will be discontinued beginning the day the child receives other creditable coverage. As described in Section 4.1.8 and 4.4.1, TPL matches will be conducted as a mechanism for detecting whether health coverage has been obtained during the eligibility period.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

Check here if this section does not apply to your state.

The following procedures would be used to determine when the State might need to consider options for containing CHIP enrollment and expenditures to ensure that Indiana's CHIP budget or annual appropriation is not exceeded. This process was approved by the Children's Health Policy Board in the spring of 2000.

The CHIP office will analyze current and past enrollment in order to determine future enrollment trends and projected enrollment levels. Both CHIP I and CHIP II enrollment will be monitored.

Based on previous expenditures, CHIP expenditures will be estimated The CHIP office will monitor projected expenses for both CHIP I and CHIP II to determine their impact on the CHIP budget.

Enrollment and expenditure projections would be utilized to develop an estimate of how many children CHIP can afford to cover under Phase I and Phase II, and determine when the state may want to consider implementing mechanisms to ensure that the CHIP budget or annual appropriation is not exceeded.

Budget limitations may be the result of the state CHIP appropriation or the annual federal allocation. If either the state appropriation or the federal allocation is exceeded, the state could

choose to:

1. Allocate additional funds from another source, such as the indigent care trust fund; or
2. Limit CHIP enrollment or expenditures to remain within the original state appropriation or federal allocation by pursuing one of the following options:
    - Cover CHIP I children at the Medicaid match rate: This would have a significant impact on the Medicaid budget.
    - Establish a waiting list for CHIP II: A waiting list would have to be automated to be efficient. This automation would result in additional cost and would require start-up time before implementation.
    - Change the benefit package for CHIP II: By analyzing the expenditures by category of service, savings could be identified by limiting coverage of certain services. This change would require significant automation costs, federal approval, and start-up time before implementation.
    - Implement additional cost-sharing requirements for CHIP II: Cost-sharing requirements could be increased to a maximum of 5% of a family's income. An automated process to monitor family cost-sharing expenditures would be required. This automation would result in additional cost and would require significant start-up time before implementation.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

All individuals who apply for CHIP will first be screened for Medicaid eligibility under Title XIX. Since the CHIP categories are lower in the hierarchy than the Title XIX categories, eligibility for Title XXI will be explored only after it is determined that a child is not eligible under Title XIX. (For a more detailed discussion, see Section 4.4.2).

Steps will also be taken to ensure that children enrolled under Title XXI do not have other health insurance. At the time of application and upon re-certification, families will have to attest to the fact that the child does not have other health insurance, and will also be required to specify when coverage was last provided. To qualify for CHIP, the child must not have had creditable health insurance during the previous three months, unless the child was involuntarily dropped from the plan or the child was previously covered under Title XIX. Since ICES captures data regarding the employment of the applicants'

parents, the system will detect children who are ineligible for CHIP due to their eligibility for dependent coverage under the state employee health plan.

As a method of further ensuring that only targeted low-income children receive services under the program, the state will conduct TPL data matches to help detect coverage under other plans.

Three primary methods of third party liability policy gathering will be utilized: absent parent data match using data from the State Wage Information Collection Agency; a match with data from the Department of Defense that shows CHAMPUS coverage for dependents, and a match through Health Management Systems which matches claims information from the IndianaAIM system with insurance information from private insurance policies. The State will utilize the employment section of the application form to identify children who are eligible for dependant coverage under the state employees health plan.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

All children who apply for Hoosier Healthwise are screened for Medicaid eligibility under Title XIX, and, if found eligible, are enrolled under the Title XIX program. The Title XXI CHIP program are categories in the ICES eligibility determination system. The ICES system establishes an applicant's category of assistance based upon a hierarchy of eligibility categories. The CHIP categories are lower in the hierarchy than the Title XIX categories, and, thus, eligibility is first explored under the Title XIX categories, and only those children with higher incomes who do not qualify under Title XIX are considered for the Title XXI program.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Children who are found not eligible for Medicaid under Title XIX, are enrolled in the Title XXI Medicaid expansion if they are up to 150% FPL and do not have other insurance. Title XIX, rather than Title XXI, is used to provide services for children who are under 150% FPL but who have other health insurance. The enhanced match does not apply for these children since they do not fall under the targeted low-income definition due to their other insurance coverage. Children who are above 150% but not more than 200% FPL, who do not have other health coverage and who meet the other CHIP eligibility requirements, are enrolled in the Phase II CHIP program if they agree to the

cost sharing obligation.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. X Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Indiana has instituted a number of mechanisms designed to address crowd out. To ensure that CHIP Phase I and Phase II enrollees do not have other health insurance, the State requires that all CHIP recipients attest to the lack of current health care coverage and specify the date of last coverage. Since Phase I of the CHIP program limited family income to 150% of poverty, crowd out is not a significant issue because many of the lower income families do not have the option of employer-based health insurance. Crowd out is of greater concern under Phase II due to the higher income threshold. As such, Indiana has instituted three-month waiting periods and monthly premiums as crowd out deterrents under the Phase II program.

The Hoosier Healthwise application asks "Did any applicants who do not have health insurance lose their coverage in the last three months? Please tell us why coverage was lost." The choices are:

* Loss of employment
* Could not afford
* Coverage limit reached
* Company ended coverage
* Non-custodial parent dropped coverage
* Divorce
* Other

This information (for both approved and denied children) is entered into the Indiana Client Eligibility System (ICES) and monitored for signs of crowd-out among applicants. Applicants who lose coverage involuntarily are not subjected to the three-month waiting period.

Denial reasons are tracked, resulting in: 1) a count of applicants who were denied because they voluntarily dropped coverage but did not wait the required three months before applying, 2) a count of applicants who were denied because they currently carry private insurance, and 3) a count of currently enrolled children who are denied because they gained private coverage rendering them ineligible

for CHIP. This information is monitored using our aggregated data system, COGNOS.

As an additional crowd out deterrent, provisions included in Public Law 273-1999 prohibit insurers from knowingly or intentionally referring children covered under their dependent coverage policies to the CHIP program.

4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Indiana contracted with the Indiana Minority Health Coalition (IMHC) to assure health assistance to targeted low-income children who are American Indians. The IMHC has a local Native American coalition which worked closely with the IMHC and the State of Indiana to develop culturally sensitive materials targeting a Native American audience. The State will continue to engage in collaborations with the Native American Minority Health Coalition to ensure that Native American children who are eligible for Hoosier Healthwise receive assistance. Currently, the Coordinator of the American Indian Center is available in an advisory role to the State of Indiana regarding this population.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

In order to reach out to families of children eligible for Hoosier Healthwise, and to encourage them to enroll their children, Indiana implemented outreach strategies which built upon efforts already underway in the State. The State's goals were to encourage simplicity, establish processes that are convenient for families, and eliminate duplicative interviewing.

Central Office Activities:

The central DFC office took a number of steps to strengthen outreach and increase enrollment. These efforts include: issuing a new policy directive regarding enhancing outreach and enrollment; analyzing the number of uninsured children per county; reviewing equipment specifications and technical needs so that local providers and agencies who want to partner with the State can purchase compatible equipment; developing a simplified shortened Hoosier Healthwise application form; including Hoosier Healthwise on a joint application that allows families to apply for Hoosier Healthwise at the same time that they apply for other programs; developing program brochures, posters, and mail-in application booklets in English and Spanish; delinking Hoosier Healthwise from TANF in the computer system; redesigning the membership card so that enrollees can be proud to carry the card; undertaking a media campaign designed to inform the public about the availability of the Hoosier Healthwise program; creating a new training curriculum for caseworkers and other individuals; and coordinating the heightened outreach campaign among the various state agencies, and promoting the new outreach efforts at a myriad of community service and health service meetings; and establishing a significant presence at Indiana Black Expo and the state and county fairs.

The DFC also met with individuals representing hospitals, schools, health centers and social service agencies to create enrollment centers statewide. These discussions led to the development of a number of models that could be utilized in different communities and in different types of settings. These models range from a co-location to a partnership where a facility hires a full-time employee to collect the necessary application information. The goal is for the information to be obtained, verified and collected by a person at the enrollment center location. This information is then forwarded to the local DFC office for evaluation and authorization.

Local Efforts:

While many policy directives were developed by the central DFC office, much of the responsibility for developing and implementing specific efforts was given to the DFC directors in the individual counties. Every DFC director was given a county-specific enrollment target and

was furnished a list of names of individuals and entities who they were required to contact to discuss outreach and enrollment center opportunities. The county directors were responsible for working with these and other potential partners in the individual communities, and for fashioning enrollment centers that meet the needs of the individual communities and the particular partners. This local design responsibility was especially important in rural areas where different outreach strategies may have to be utilized.

The county directors were also required to develop local outreach plans geared to the specific communities. These plans were developed with input from the local office staff, local welfare planning councils, local health departments, local health care providers, Step Ahead Councils, and other community planning boards that address children's issues. The county directors' increased involvement with their communities enhanced their ability to connect children with other appropriate child-related programs in Indiana. It also provided them with new opportunities to coordinate Hoosier Healthwise outreach with outreach for other child-related programs.

State and Local Collaborations:
The State also worked with eight community coalitions on a three year Robert Wood Johnson (RWJ) *Covering Kids* outreach grant which targeted hard to reach populations.

Provisions designed to encourage outreach at the community level are included in Public Law 273-1999. The statute provides that the CHIP program may contract with community entities for services such as outreach and enrollment, and consumer education.

Special Populations:
The State has contracted with Black Expo, the IMHC, and the Wishard Hospital Hispanic Health Access Initiative to develop culturally sensitive materials and to implement outreach initiatives. The Consolidated Outreach Project (COP) was also utilized to provide outreach for children in families of migrant farmworkers.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. X Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions. (See Attachment A, benefits package, and Attachment B, actuarial opinion memo)**

6.1.3. Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. Coverage that either includes the full EPSDT benefit or

that the state has extended to the entire Medicaid population

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by "existing comprehensive state-based coverage"

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

For discussion of scope of services, amount, duration, exclusions and limitations, see Attachment A.

6.2.1. X Inpatient services **(Section 2110(a)(1))**

6.2.2. X Outpatient services **(Section 2110(a)(2))**

6.2.3. X Physician services **(Section 2110(a)(3))**

6.2.4. X Surgical services **(Section 2110(a)(4))**

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. X Prescription drugs **(Section 2110(a)(6))**

6.2.7. X Over-the-counter medications **(Section 2110(a)(7))** Coverage only applies to insulin.

6.2.8. X Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. X Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. X Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. X Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. X Disposable medical supplies **(Section 2110(a)(13))** Coverage subject to limitations.

6.2.14. X Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. X Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. X Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. X Dental services **(Section 2110(a)(17))**

6.2.18. X Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. X Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. Case management services **(Section 2110(a)(20))** Not Covered.

6.2.21. Care coordination services **(Section 2110(a)(21))** Not Covered.

6.2.22. X Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. X Hospice care **(Section 2110(a)(23))**

6.2.24. X Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. Premiums for private health care insurance coverage **(Section 2110(a)(25))** Not Covered.

6.2.26. X Medical transportation **(Section 2110(a)(26))**

6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))** Not Covered.

6.2.28. X Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through

cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

Not Applicable.

6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a)):**

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the

amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Indiana will utilize a number of different strategies to assure quality and appropriateness of care under the CHIP program. The State contracts with an evaluation consultant who develops and updates performance criteria, and also provides assistance in producing the evaluation and annual reports. The performance criteria are an important tool for measuring quality of care, particularly with respect to well-baby care, well-child care, and immunizations. Hoosier Healthwise uses NCQA's HEDIS measures to monitor quality. A more detailed discussion of performance measures and the evaluation consultant can be found in Section 9.

Quality assurance requirements are imposed on MCOs that contract with the State under Hoosier Healthwise. MCOs must have quality improvement (QI) programs in place that meet the federal requirements (42 CFR 434.34) and the National Committee for Quality Assurance (NCQA) standards. The QI programs must be based on annual plans that are approved by the OMPP. In addition, MCOs must meet a number of other QI requirements, including: establishing a QI Committee overseen by the MCO Medical Director; submitting Quarterly QI reports; conducting focused studies, including medical data abstraction and data entry, in areas of clinical priority for the Indiana Medicaid population; establishing internal systems for monitoring services; conducting a quality of care chart audit of providers of services; attending monthly Hoosier Healthwise Quality Improvement Committee (QIC) meetings; submitting QI data to the State; and taking other steps to improve quality of services.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards

- MCOs that provide services under Hoosier Healthwise must have QI programs in place that meet NCQA standards.

- PMPs will be required to comply with universally accepted standards for preventive care, as endorsed by the American Academy of Pediatrics, the Academy of Family Physicians, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine. Specifically, these standards apply to the

following areas: childhood immunizations, pregnancy, lead toxicity, comprehensive well child periodic health assessment, HIV status, asthma, diabetes, ETOH and drug abuse, sexually transmitted diseases, motor vehicle accidents, pregnancy prevention, prevention of influenza, smoking prevention and cessation, and others. Clinical practice guidelines from the Agency for Health Care Policy and Research and the Indiana Medicaid Coordinated Care Technical Assistance Group (TAG) may also recommended.

- Through the Clinical Advisory Committee, providers provide the OMPP with input on Hoosier Healthwise policies affecting quality, accessibility, appropriateness and cost effectiveness of care.

- The Hoosier Healthwise QIC oversees quality of care and appropriateness of care and integrates the quality improvement process. The QIC membership consists of MCO medical directors, MCO QI staff representatives, the OMPP staff members, and representatives of Health Care Excel and Lifemark. MCOs must provide the QIC with monthly reports regarding inquires made through the plans' toll free numbers and provide a status update on all grievances.

- Requests to disenroll are documented, tracked and monitored.

7.1.2. X Performance measurement

- MCOs must conduct annual member satisfaction surveys, and present this information to the OMPP, recipients and providers.

- The State conducts annual recipient surveys.

- MCOs must comply with scheduled HEDIS measures.

- The evaluation consultant will develop performance criteria to measure the quality of services provided under CHIP. These measurements will include health status indicators and EPSDT compliance.

7.1.3. X Information strategies

- Hoosier Healthwise applicants are provided with materials regarding managed care; PMPs; MCOs; preventive services; 1-800 telephone hotline; emergency room usage; grievance procedures; recipients' rights and responsibilities; coverage, cost and claims; and a summary of program activities.

- The State conducts provider training and benefit advocate training. Indiana has

implemented an enhanced outreach campaign.

7.1.4. X Quality improvement strategies

- The State has a toll free 1-800 telephone number for recipients and providers. Staff investigates inquires and complaints received through this phone line.

- The State monitors PMPs 24-hour accessibility by making random calls to PMPs during regular business hours and after hours.

- The State monitors several key indicators to assure that access problems do not arise. These indicators include: waiting periods; access to care after hours; referrals to specialists; and access to emergency or family planning services.

- MCOs must conduct focus studies on areas of clinical priority.

7.2. Describe the methods used, including monitoring, to assure: (**2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

- The State employs an External Quality Review Organization (EQRO) that monitors and assesses the quality of and access to health care enabled by Hoosier Healthwise. Advising the monitoring process is a Quality Improvement Committee, a Clinical Advisory Committee, and a Focused Study Workgroup. These committees along with OMPP and its EQRO have begun, in 2001, to collect data and assess providers' ability to ensure access of care to well- babies, children, and adolescents. These types of prevention services are being measured using the Health Plan Employer Data Information Set (HEDIS). For the first full year of data collection (2001), measures include the following:
  - Childhood Immunization Status
  - Adolescent Immunization Status
  - Children's Access to Primary Care Practitioners
  - Prenatal and Postpartum Care
  - Well-Child Visits in the First 15 Months of Life
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
  - Adolescent Well-Care Visits
  - Frequency of Prenatal Care

- Data collected by the EQRO are shared with CHIP's independent evaluation consultant who refines information for the purpose of assessing CHIP's programmatic effectiveness in this area.

- CHIP monitors the size of Primary Physician panels monthly.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

The evaluation consultant is responsible for updating and developing tools to measure the utilization of health services. The measurement set will be intended to assess how often, how effectively and how appropriately enrollees are utilizing services under the program.

Since the number of panel slots available exceeds the number of individuals that would be expected to enroll in both the CHIP and Medicaid components of Hoosier Healthwise, Indiana expects there to be sufficient providers available to serve all CHIP enrollees. The State will monitor panel size and PMP to recipient ratio to ensure that there is not a problem. For the counties where there is a concern about the number of PMPs participating in Hoosier Healthwise, the State will continue to provide targeted recruitment efforts and take other steps to make certain that enrollees are able to access services. For a more detailed discussion regarding sufficiency of participating providers, see Section 3.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

All Hoosier Healthwise members are allowed to select a Primary Medical Provider. If one is not selected within 30 days, a PMP will be assigned to them. By ensuring that all members have a medical home, chronic, complex, or serious medical conditions can be closely monitored and appropriate referrals can be made when necessary. In addition, Hoosier Healthwise works closely with other programs that provide wrap-around services to members. These services are available through Indiana First Steps and the Children's Special Health Care Services at ISDH. Hoosier Healthwise has a common application with these programs and refers members to them when appropriate. For a more detailed discussion on the coordination of services with these programs, see Section 2.3.

When the network is not adequate for the enrollee's medical condition, managed care organizations are required to allow members to access to out-of-network providers.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient,

within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are completed in accordance with the CHIP administrative rules, found in Title 407 of the Indiana Administrative Code, Section 3-3-2:

"The procedures and requirements set forth in 405 IAC 5-3 and 405 IAC 5-7 for Medicaid prior authorization, administrative review, and appeals shall apply to the Children's Health Insurance Program." This authority is granted by IC 12-17.6-2-11.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. X YES

8.1.2. NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Sliding scale premiums (see chart below) will be imposed on families of children eligible for Title XXI under Phase II of the program. Cost-sharing for these families (with incomes above 150% of FPL), will not exceed five percent of the family's yearly income. Individuals eligible under Phase I of the program (with incomes up to 150% of FPL) will continue to comply with cost-sharing limitations established under Medicaid. Phase II individuals pay premiums monthly.

At the time of application, applicants must sign a statement agreeing to fulfill any cost-sharing responsibilities. If they are unwilling to sign this statement, they will be informed that they may still be eligible for Medicaid (including the Medicaid expansion under Phase I), but will not be eligible for the CHIP Phase II program. If the applicant agrees to the cost sharing responsibilities, and is determined to be eligible for CHIP II, ICES holds the account in suspense, and information regarding the eligibility status and cost-sharing responsibilities is transferred to the premium-collection vendor. The premium-collection vendor issues a premium statement and provides detailed information regarding the cost-sharing requirements. If the premium is paid by the due date, the premium-collection vendor transfers this information to ICES and the applicant's account is changed from suspended status to enrolled. The applicant becomes retroactively eligible for CHIP coverage beginning the first day of the month the application was submitted to the DFC.

If the premium is not paid by the due date (the 12th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment

by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program.

PREMIUMS

Income (as a percent of FPL)	**One Child**	**Two or More Children**
150 to 175 percent	$11.00	$16.50
175 to 200 percent	$16.50	$24.75

8.2.2. Deductibles:

Not Applicable.

8.2.3. Coinsurance or copayments:

Copayments for certain services will be imposed under the Phase II program. (See chart below). These copayments will be established primarily as a utilization control mechanism. Providers will be responsible for collecting these nominal copayments.

COPAYMENTS

Service	**Copayment**
Prescription Drugs — Generic, Compound and Sole-Source	$3
Prescription Drugs — Brand Name	$10
Emergency Ambulance Transportation	$10

8.2.4. Other:

Not Applicable.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

A number of methods have been used to inform the public about cost-sharing requirements under CHIP. These include:

- notice in the Hoosier Healthwise brochure;
- notice in the application form (if the family does not agree to the cost-sharing requirements under CHIP II, the child will be considered only for Medicaid and will not be considered for CHIP II);
- notice in the conditional approval form which is sent to the family after the child is found conditionally eligible for CHIP but before the family has received the premium notice;
- notice in the first premium voucher which is sent to the family by the premium collection vendor; and
- notice in the members' handbooks which are sent once the first premium has been paid and the child has been enrolled.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. X Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. X No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 X No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Since the cost-sharing requirements imposed under the Phase II program are set relatively low, a formal tracking mechanism for the 5 percent cost-sharing maximum will not be necessary. As an additional precaution, however, Indiana will utilize a "shoe box" approach, similar to that used by the Massachusetts CHIP program. In cases where the 5 percent cap is reached, families can submit copies of their expense receipts to the program. After the program verifies that the 5 percent maximum has been met, the family's cost sharing responsibilities will cease for the year involved. Should any payment exceed the 5 percent threshold amount before a determination is

made that the 5 percent maximum has been met, payments will be promptly refunded. The 5 percent maximum is calculated based upon the gross annual income of the enrollees' families from the first day of the month following authorization of the application — the date when the eligibility period begins and the month for which families begin paying the premiums.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

Targeted low-income children of American Indiana and Alaskan Native families are excluded from the cost-sharing requirements of CHIP II. The Indiana Client Eligibility System (ICES) has been modified to allow a manual system override procedure to exempt these individuals from cost-sharing once they have been deemed eligible.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

If the premium is not paid by the due date (the 12th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program.

In both situations above, the applicant or enrollee will receive an ICES notice that provides for appeal of the closure or denial decision. The notice states in part:

"You have the right to appeal and have a fair hearing. An appeal will be accepted it is received within 30 days of the effective date of the action, whichever is later. We will allow 3 extra days for mailing.

If you wish to appeal, send a signed letter to your local Office of Family and Children at the address at the top of this Notice. If you prefer, you can send your appeal to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, room W392, Indianapolis IN 46204. If you have questions, please contact your caseworker.

You will be notified in writing of the date, time and place for the hearing. You can represent yourself, or have someone represent you such as attorney, friend, or relative. If your wish to have legal representation and cannot afford it, you may call the Legal Services Organization serving your area at (800) 869-0212."

Enrollee non-payment of cost-sharing fees for generic and brand name drugs may result in the pharmacist failing to dispense the medication sought.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- X The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**
- X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. X No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. X No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

See Chart.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

See Chart.

9.1 Strategic Objective	9.2 Performance Goal	9.3 Objective Means of Measuring Performance
9.1.1 Targeted low-income children will have health insurance through Indiana's Title XXI program.	By September 30, 2002, 52,000 targeted low-income children will have health insurance through Title XXI.	Hoosier Healthwise data will reveal the number of children enrolled under Title XXI.
9.1.2 Children enrolled in Indiana's Title XXI Program will have a consistent source of care medical and dental.	By September 30, 2002, 100% of children enrolled in the Title XXI program will select or be assigned a PMP. By September 30, 2002, 95% of children enrolled in the Title XXI program will self-select a PMP.	Hoosier Healthwise enrollment data in the IndianaAIM system will verify PMP selection or assignment. Hoosier Healthwise enrollment data in the IndianaAIM system will verify PMP selection.
9.1.3 Parents of children enrolled in XXI will be satisfied with the program.	At least 75% of parents surveyed during the first year of their child's participation under the Title XXI program will express overall satisfaction with the program.	Hoosier Healthwise recipient survey results will be utilized to show the satisfaction rate.

9.1.4 Providers who participate in Indiana's Title XXI program will express satisfaction with the terms and conditions of their participation.	At least 50% of providers surveyed will express overall satisfaction with the Title XXI program.	Annual Hoosier Healthwise provider survey results will be used to show the provider satisfaction rate.
9.1.5 Children enrolled in Indiana's Title XXI program will enjoy improved health status.	At least 60% of 2 year olds enrolled in the Title XXI program will receive immunizations consistent with HEDIS recommendations. At least 60% of enrollees in the Title XXI program will receive recommended preventive services.	Reporting by Hoosier Healthwise providers will be used to verify percent of 2 year olds receiving immunizations as per HEDIS recommendations. Sample chart reviews will be used to indicate the percent of enrollees who received well-child services.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

See Chart.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. X The reduction in the percentage of uninsured children.

9.3.3. X The increase in the percentage of children with a usual source of care.

9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. Immunizations
- 9.3.7.2. Well child care
- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list:

9.3.8. Performance measures for special targeted populations.

9.4. X The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. X The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The State assures that it will submit the evaluation required under Section 10 by January 1st of each year. The State also assures that it will complete an annual assessment of the progress made in reducing the number of uncovered low-income children, and report to the Secretary on the result of the assessment.

The assessments will be based largely upon the strategic objectives set forth in Section 9 and program evaluation criteria designed by the evaluation consultant. The strategic objectives focus on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, and improving health status. The data used to measure performance will be compiled from existing databases. In addition, child-relevant HEDIS measures are being used to assess the quality of care provided to Hoosier Healthwise children.

9.6. X The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. X The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. X Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

Public Input on Plan Design:

In designing the first and second phases of the CHIP program, Indiana developed a public input plan that included several different levels of discussion, and which capitalized on the expertise and experience of a myriad of individuals and entities within the state. This input included:

- A twenty-one member bi-partisan Governor's Advisory Panel representing a cross-section of Indiana experts was appointed to develop a blueprint on implementation of the CHIP program. Members on the panel included: hospital representatives, physicians, insurance executives, parents, advocates, school officials, health clinic representatives, and members of the Indiana General Assembly. Numerous press releases were utilized to publicize the work of the Advisory Panel. All meetings were publicized and covered by the news media. Further, there was significant news coverage during the General Assembly's deliberations on the Governor's CHIP proposal.

- Five subcommittees were established to provide a broader range of input and allow for in-depth discussion and analysis on key areas of importance. Membership on the subcommittees included: hospitals, physicians, nurses, pharmacists, local health department representatives, optometrists, mental health providers, economists, academics, numerous community and social services programs, migrant farmworkers and homeless parents, and various other experts. The subcommittees focused on the following key

topics: Coordination/Infrastructure/Provider Supply/Community Systems; Benefits and Cost Sharing; Eligibility and Crowd Out; Outreach and Education; and Data, Evaluation and Outcomes. The subcommittees' reports were submitted to the Advisory Panel for consideration.

- A series of eight public forums were held across the state in order to allow for a wide range of input from individuals and entities within individual communities. The forums provided opportunities for citizens to share their concerns regarding methods for improving and for building upon the state's current health care system, and mechanisms for encouraging parents to access health services. In order to maximize awareness and participation, the forums were held at a number of different sites and at varying times. The local social service and health promotion agencies helped select the most appropriate time and location for each hearing. To promote the forums, the organizers worked closely with numerous individuals and entities. Assistance was provided by the local WIC sites, local MCH agencies, local immunization sites, local Medicaid providers, community health centers, local DFC offices, the LHDs, and the Indiana Coalition on Housing and Homeless Issues. In order to make it easier for parents to attend, child care was provided during the forums. Individuals who were not able to attend were encouraged to submit written comments. State and local news media were notified in advance of all public forums through a myriad of sources. News releases, media advisories and telephone calls were all utilized in an effort to maximize press coverage.

- Numerous focus groups were established to draw upon the expertise, experience, and perspectives of homogeneous groups of individuals. The focus groups consisted of groups of providers, advocates, parents and adolescents. The groups met in various locations throughout the State and discussed key issues from their own specific perspectives.

- The Phase II benefits package was sent to a large audience with requests for comments.

- Discussion of plan design was also possible during the rulemaking process. A public hearing was held during this process.

- As part of its CHIP oversight responsibility, the Policy Board established broad based committees in the areas of: children with special health care needs, data, and program coordination.

- Legislative oversight of the CHIP program will be provided by the Select Joint Committee on Medicaid Oversight.

Promotion of Plan Implementation:

The Chair of the Governor's Advisory Panel appeared before various editorial boards as a means

of increasing awareness of the CHIP program. A CHIP website was developed to provide information regarding the CHIP program. This website (http://www.in.gov/fssa/programs/chip) is updated regularly and also includes a link to the Hoosier Healthwise website for families. Radio and television public service announcements were aired throughout the State. A radio blitz that included information about Hoosier Healthwise in a "Back to School" message was run throughout the State. Billboards, bus placards, and newspaper ads have also been used to promote the program. And, with the assistance of local DFC offices, local newspapers have run articles informing families about Hoosier Healthwise.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Indiana contracted with the Indiana Minority Health Coalition (IMHC) and Wishard Hispanic Health Project during the design, implementation, and early stages of the CHIP program to develop culturally sensitive materials targeting a Native American audience and to assure that Native American children who are eligible for the program received assistance. Currently, the Coordinator of the American Indian Center is available in an advisory role to the State regarding this population.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

In the 2002 Indiana legislative session, state law (P.L. 107-2002) was passed to eliminate continuous eligibility from Hoosier Healthwise. As a result, it was necessary to amend our CHIP administrative rules. As required by Indiana's rulemaking statute (IC 4-22-2), the agency provided public notice of the change before the rule was adopted. The proposed rule was published in the Indiana Register on June 1, 2002. Notice of the public hearing concerning the proposed change was published in the Indianapolis Star newspaper on May 24, 2002. A public hearing was held June 24, 2002. The agency complied with the public notice requirements prior to the July 1, 2002 effective date of the change in eligibility.

In addition to the public notice required by the rulemaking process, we provided notice of the change to all Hoosier Healthwise members. All Hoosier Healthwise members were sent a notice between June 17, 2002 and June 21, 2002 advising them of the change in law and how it would affect them. In addition, the CHIP premium collection vendor also sent flyers out with members' invoices in order to provide them with an additional reminder of the change in eligibility. These flyers were included with the June, July, and August 2002 invoices.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including –
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

There have not been any programmatic changes with a significant impact on the currently approved budget, attached.

	FFY 1999	FFY 2000	FFY 2001	
BENEFIT COSTS				
Insurance Payments				
Managed Care	63,434,000	80,704,000	95,354,000	
Per member/ per month @ # of eligibles	146.83/per month @ 36,000	140.11/per month @ 48,000	124.15/per month @ 64,000	
Fee-for-Service	0	0	0	
TOTAL BENEFIT COSTS	63,434,000	80,704,000	95,354,000	
(Offsetting beneficiary cost sharing payments)	0	1,620,000	5,040,000	
Net Benefit Costs	63,434,000	79,084,000	90,314,000	
ADMINISTRATION COSTS				
Personnel	130,000	385,000	400,000	
General Administration	1,658,000	3,615,000	3,625,000	
Contractors/Brokers (e.g. enrollment centers)	600,000	1,385,000	1,285,000	
Claims Processing	540,000	1,165,000	865,000	
Outreach/Marketing Costs	0	100,000	100,000	
Other	0	1,146,000	146,000	
TOTAL ADMINISTRATION COSTS	2,928,000	7,796,000	6,421,000	

10% Admin Cost Ceiling	0	0	0
Federal Shared (multiplied by enh-FMAP rate)	48,251,810	64,799,700	74,519,655
State Share	18,110,190	23,700,300	27,255,345
TOTAL PROGRAM COSTS	66,362,000	88,500,000	101,775,000

Notes:

1. Increases in total program costs of approximately 25 percent in FFY 2000 and 15 percent in FFY 2001 from the previous year are anticipated.
2. Total benefit costs for FFY 2000 assume that expenses will be higher during the first year of CHIP Phase II than subsequent years due to pent-up demand and adverse selection.
3. The estimates for beneficiary cost-sharing payments were based on an average of $15 per month per beneficiary enrolled in CHIP Phase II.
4. Managed care includes both primary care case management and risk-based managed care. All CHIP beneficiaries will be enrolled in either primary care case management or risk-based managed care. Primary care case management providers are reimbursed on a fee-for-service basis.

Funding Source:

The state portion of the expenditures will be generated from the State's tobacco settlement money. State general revenues will be used as a supplement, if needed.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 X The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. X Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. X Section 1128A (relating to civil monetary penalties)
- 11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters and Health Services Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR §457.1120.

See section 12.2.

12.2 Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

The Division of Family and Children is responsible for determining eligibility for the aid categories that provide medical assistance through CHIP. The DFC has a comprehensive hearings and appeals process in place for all public assistance programs, including Medicaid and CHIP. The following is their policy on the review process for both eligibility and medical assistance matters.

All individuals must be informed in writing at the time of application and when action is taken which affects their benefits, of: the right to a fair hearing; and the method for requesting a hearing. This information is contained in the Rights and Responsibilities listing which is given to applicants, and is also on all eligibility notices. The freedom to make such a request must not be limited or interfered with in any way.

The Local Office of Family and Children is responsible for assisting a dissatisfied individual so that he may fully exercise his right to appeal. Any time an individual expresses a disagreement with any action taken, he must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual who is having difficulty in preparing the written request for an appeal. The individual is to be informed that he may represent himself at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of his choice. Information and referral services should also be provided to help the dissatisfied individual make use of any free legal services that are available in the community.

Any action with which an applicant/recipient is dissatisfied may be appealed. An applicant may appeal and have a fair hearing when his application for financial or medical assistance is denied or not acted upon with reasonable promptness. A recipient may appeal when he believes the Local Office has taken erroneous action to reduce, suspend or discontinue assistance. In addition, a recipient or provider of medical services may appeal an action to deny or limit services under

the Medicaid program.

Below is the language found on all CHIP eligibility notices:

"You have the right to appeal and have a fair hearing. An appeal will be accepted if is received within 30 days of the effective date of the action, whichever is later. We will allow 3 extra days for mailing.

If you wish to appeal, send a signed letter to your local Office of Family and Children at the address at the top of this Notice. If you prefer, you can send your appeal to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, room W392, Indianapolis IN 46204. If you have questions, please contact your caseworker.

You will be notified in writing of the date, time and place for the hearing. You can represent yourself, or have someone represent you such as attorney, friend, or relative. If your wish to have legal representation and cannot afford it, you may call the Legal Services Organization serving your area at (800) 869-0212."

FSSA requires an expedited review process for medical services when requested by the enrolled member in certain situations. Each MCO is contractually required to "make available an expedited informal and formal grievance procedure for member grievances that cannot be delayed without risking permanent damage to the member's health," and the expedited review must be completed within 72 hours. Members are notified by their delivery system (RBMC or PCCM) of this option. Each delivery system has a member handbook that gives guidance on this issue. For example, the MDwise MCO member handbook states: "In an emergency, grievances will be handled quickly. This is called an "expedited" grievance or appeal. If your case can be expedited, we will review your case and notify you of a decision within 72 hours. Call us at (317) 630-2831 or 1-800-356-1204 to see if this can be done." The review process is in compliance with Indiana's health insurance law, I.C. 27-13-10.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

N/A